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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #11-030-9016
Alden Village North Health Facility

Case summary: The HRA substantiated the complaint that the facility did not follow Code procedures when it began sending the recipient for psychiatric evaluations after a staff person reported that she had been slapped by another staff. The HRA did not substantiate the complaint that the recipient was discharged to another facility that was not qualified to treat her. The facility response was accepted by the HRA however is not attached at the request of the provider.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Alden Village North Health Facility (Alden). It was alleged that the facility did not follow Mental Health Code requirements when it began sending a recipient for psychiatric evaluations after a staff person reported to the police that she witnessed another person slap the recipient while she was showering. Also it was alleged that the recipient was then discharged to a facility that was not qualified to treat her. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45 et seq.), and the Mental Health and Developmental Disabilities Act (405 ILCS 5 et seq.).

Alden Village North is a skilled nursing facility with 123 licensed beds. Alden provides orthopedic and neurological rehabilitation, respiratory care, pain management, post-operative care, respite care, hospice care and long term and skilled nursing for children and young adults.

To review this complaint, the HRA conducted a site visit and interviewed the Administrator and the Resident Services Director. The HRA obtained the recipient's record with written consent.

COMPLAINT SUMMARY

The complaint indicates that on 11/02/2010 a staff person reported to the police that another staff person had slapped the recipient while she was showering. After this incident, the complaint alleges that the facility began sending the recipient to the hospital for psychiatric evaluations, even though it was unnecessary and repetitive. The complaint states that the recipient was then discharged to a facility that was not qualified to care for her.

FINDINGS

The Alden Village North facility was opened in 2004 and at this time the recipient was admitted into the facility. From the period of the recipient's admission until 11/02/10 the recipient was hospitalized one time on 10/10/2008 (although staff report that this was for an actual hospitalization and that emergency room visits that did not result in admission would not be noted in the record).

The record shows that the recipient's diagnosis was "profound mental retardation with behavioral disturbance and psychotic features, seizure disorder, encephalitis, osteoporosis, and lymphadema". The record contains monthly QMRP summaries for the months of August, September, October, November, and December of 2010. Each summary states that there are "no issues or concerns." The recipient's goals and objectives are similar for all the reporting period and they include 1) Recipient will wipe off the table area in dining room with verbal prompt 55% of the time, 2) Recipient will trade one object for another with verbal prompt 65% of the time, 3) Recipient will say "please" when staff offer her an object that she wants with verbal prompt 65% of the time, 4) Recipient will use soap on her hands independently 65% of the time, and 5) Recipient will trade money for items (pop, coffee, musical object) 1 time with verbal prompt for three consecutive months. The summaries contain a behavior component which outlines the recipient's management plan: For month of August: "[Recipient] has a history of self-injurious behaviors such as banging her arms and hands on walls, aggressive behaviors (i.e. throwing objects), and disruptive behaviors (i.e. spontaneous yelling, screaming, entering others' rooms). During the month of August she was found to have attempted to bite or scratch herself 0 times, banged her arms 1 time, played with her breasts 0 times, had physically aggressive behaviors 0 times, and wandered into others' rooms/taking things that do not belong to her 0 times over period of 21 days. She continues to be monitored by staff and have aid in behavior regulation and medication management." For the month of September the recipient increased the number of times she banged her arms (6), played with her breasts (19), had physically aggressive behaviors (39), and wandered into others' rooms taking things that did not belong to her (100) over a period of 27 days. In October the recipient again increased her self injurious behaviors (47), engaged in self-stimulating behaviors (14), was verbally aggressive (6), physically aggressive (42), and wandered into others' rooms, taking things that did not belong to her (113) over a period of 31 days. In November, the month of the recipient's attack, the recipient increased her attempts to engage in self injurious behaviors (76), engaged in self stimulating behaviors (32), was verbally aggressive (86), physically aggressive (90), and wandered into others' rooms, taking things that did not belong to her (105) over a 30 day period.

The record contains the Incident Report describing the recipient's attack. To describe the incident it states, "As reported, CNA… observed patient… being slapped in the upper section of her back by CNA… whilst in the process of giving her a shower." A Post Incident Report is included which indicates that the CNA has been removed from contact with the recipient and the police report is attached. An Incident Notification Follow-up offers the following summary: "An allegation was reported to the Administrator on 11/02/10 by an employee. Per report, a CNA had witnessed another CNA slap a resident on the back at approximately 7:30 p.m. in the shower room. An investigation was immediately initiated. The nurse on duty did a full body assessment and there were no indicators of pain or injuries noted. Primary physician and legal guardian

were notified. The employee was immediately suspended pending the investigation completion. Based on investigation and staff statements, the allegation has been substantiated. The employee,…, will be terminated. The resident appears to be exhibiting normal behaviors since the incident. The report indicates that a final report has been faxed to the Department of Public Health on 11/06/10.

There is no mention of the recipient's attack in any of the progress notes in the record. Although monthly reviews of the Behavior Plans are included in the record, none of them mention the attack, even when the physician decreases and then increases the recipient's medication due to her increased aggressiveness. Special staffing notes contain an area to address any major events or significant changes in the resident's life in the past year and never is the incident mentioned. Although the recipient's aggressive behaviors are described in detail in every treatment document, the Care Plan and staffings never address the violence that was perpetrated on the recipient. The progress notes indicate on 11/14/10 that the recipient was placed on an updated behavior plan and the record notes that it was signed by the recipient's guardian. On 11/22/10 the progress notes state, "[Recipient attends [in-house programming] Mon- fri. Health is stable. Currently on behavior plan. She's on psychotropic medication to aid in [negative] behaviors. [Recipient] is very difficult. Screaming and not cooperating throughout the day, other times she's happy, laughing and smiling. Her sister is her guardian. She remains appropriately placed."

On 12/09/10 the record indicates that the recipient was sent to the hospital for a psychiatric evaluation: "[Recipient] went out to ER for psych evaluation. [Recipient] has been hitting her peers. Two incidents occurred in [day] program this week. Currently on behavior plan, but behaviors are still present. [Recipient] at times can be very disruptive and resistive to care." The petition for involuntary admission, completed by the unit nurse, is included in the record for this event and the signs and symptoms of mental illness listed on the document states, "12/08/10 resident hit co-resident redirected with fair result. …(illegible). 12/9/10 resident punch another resident in right arm. Staff intervene, resident hit staff. Redirected with fair to poor result." On 12/27/10 the staff met with the recipient's family to discuss behavioral concerns and this meeting resulted in the recipient being placed on 1:1 observation by staff. On 1/11/11 the behavioral plan was again modified due to the recipient's resistance to the day program, and it was decided that she would not attend the day program for two weeks to see if her behaviors improved.

On 1/21/11 the record indicates that the recipient was hospitalized for a psychiatric evaluation: "RSD [Resident Services Director] contacted [hospital] in an effort to have [recipient] admitted for psych eval due to an increase in …violence toward staff and other residents. RSD spoke with [staff] at [hospital] who ultimately decided [recipient] was too 'medically complicated' to admit. RSD then called [recipient's] psychiatrist who authorized admission to the ER but suggested speaking with [recipient's] physician to determine which location [recipient] should be admitted. RSD informed DON of need to contact physician." There is no petition included for this hospitalization and the record does not describe the aggressive behaviors, when they took place, or any circumstances surrounding these events. Also, the record does not indicate what hospital the recipient was admitted into, however it does indicate she was discharged 1/26/11.

On 2/08/11 an entry in the progress notes states, "Spoke with guardian regarding peer to peer altercation that occurred today and again discussed [recipient's] history of peer to peer altercations. [Guardian] expressed understanding that [recipient's] behaviors have increased and that the facility needs to keep the protection of the other clients in mind. [Guardian] expressed interest in placing [recipient] at one of our 16 bed homes, but there is no availability at this time. [Guardian] asked if she could be placed on a waiting list. Writer notified [guardian] that it would not be realistic to expect an opening within the next 30 days. At this time it was also explained that an Involuntary Discharge/transfer notice was to be sent out via certified mail. [Guardian] expressed understanding and requested that we all work together to find a facility closer to …to allow more visitation time."

On 2/11/11 the recipient was again hospitalized for a psychiatric evaluation. There is no accompanying petition for this event, and no symptoms of mental illness which would indicate the need for an involuntary psychiatric evaluation. Progress notes indicate that the administrator spoke with the recipient's guardian about seeking another placement for the recipient due to the steady increase in aggressive behaviors towards peers. On this date the facility issued a Notice of Transfer or Discharge and Opportunity for Hearing. The effective date of the proposed transfer or discharge is 3/17/11 for the reason of "safety of individuals in this facility is endangered."

On 2/16/11 the progress notes indicate another hospitalization: "[Recipient] engaged in another peer to peer altercation. Guardian was notified that [recipient] would be sent to …hospital for psychiatric evaluation. It was also explained that should [recipient] be admitted to the hospital, the facility would not be readmitting her. [Guardian] expressed understanding." The recipient was then discharged after her evaluation. On this date there is another entry stating, "Contacted Administrator of Alden Lakeland [sister company of Alden North], to arrange for transfer to geri-psych unit pending guardian approval. Admin. confirmed bed availability and will wait to hear back to coordinate transfer."

The record (Nurse's Notes on 2/17/11) also indicates that the facility made an attempt to get the recipient admitted to another home, chosen by the guardian, however the facility declined the recipient's admission. On 2/17/11 the progress notes state, "Spoke with [guardian]… [Guardian] is trying to place [recipient] into another facility. She does not want [recipient] to go to the facility chosen by [physician]. [Guardian] wants to ensure that [recipient] goes to a facility that's good and can meet her needs. [Recipient] returned from hospital with an order for new psych. medication. HRC [Human Rights Committee] does not approve new order at this time." The final nursing note entered on 2/17/11 indicates that the recipient will be transferred to Alden Lakeland and states, "…[Guardian] was in agreeance [sic] with sending the patient to Alden Lakeland and voiced understanding of the need for transfer. [Guardian] had no complaints at this time and thanked the facility for helping with this matter."

FACILITY REPRESENTATIVE RESPONSE

Facility staff were interviewed regarding the complaint. They stated that the recipient had ongoing problems with aggression and acting out behaviors for many years. They stated that the recipient had been recommended for the in-house day programming, which she did not want to participate in. In order to get out of this programming, she would slap or pinch a fellow resident and this would cause her to be pulled from the program and she could then be free to read magazines or pursue her rummaging behaviors. After the number of incidents involving her aggression increased, she was given a staff person for 1:1 observation and she particularly disliked this close contact. Finally, the day programming was suspended for the recipient to determine if this was the cause of her aggression, however she continued to act out. Staff stated that they implemented a number of interventions to address the behaviors: staff were changed, new staff were introduced, stations were set up to allow her to rummage, fill containers, and even scavenger scenarios were implemented to engage her (these are not noted in the clinical record). Staff stated that they came to realize, and they thought that her guardian realized as well, that she was no longer appropriate for the program and she needed a change. The recipient had been at the facility a number of years, was older than many of the other residents, and needed to be in a facility with people of her own age. Staff stated that the facility had suffered several negative incidents the year before these events and had been monitored by the Department of Public Health. Thus, in order to intervene immediately when the resident became physically threatening, the staff would petition the resident for a psychiatric evaluation to determine the cause of her aggression and prevent escalation or even harm to the resident and others. The hospitalizations were a direct attempt to address the immediate threat posed by the resident. (Note: Staff reported that the resident did not injure other residents or staff but rather slapped or pinched them for the effect of getting something that she wanted).

Staff were interviewed about the fact that the incident of the recipient being slapped by staff was never mentioned in the notes, care plan or behavioral plan, and that this could have been the reason the recipient became aggressive. Staff reported that they were not aware that the incident was never mentioned and could not offer an explanation for why it was not included. They did feel that the aggression was addressed by the many interventions that were utilized, however these interventions were not written in the record. Staff did report that over the past year the facility has addressed all their recordkeeping and have implemented changes in the format of progress notes, care plans, and QMRP summaries that reflect the individual needs, behaviors, and interventions for each recipient. Staff suggested that the two staff persons involved in the slapping incident did not like each other, and there is the possibility that the incident did not happen, thus it was not recorded in the record. The HRA notes, however, that the staff person involved was fired as a result of this incident, so some measure of confirmation occurred. Additionally, HRA staff noted that the abuse of the staff member could have been occurring over a period of time before the incident was reported.

Staff were interviewed about the recipient's placement after discharge from Alden. They stated that the recipient's guardian had requested a placement close to her and had selected a facility, however when the Alden staff called to secure this placement, the facility declined the recipient. Staff believed that the reason the recipient was declined was the report of aggression and the need for 1:1 monitoring. The administrator suggested that the recipient be placed in a another setting (still a skilled nursing facility) where she could gain some control over the aggression and then after several months without any aggression and with the 1:1 monitoring

lifted, she could once again apply to her guardian's preferred placement. Staff have visited the recipient in her new setting and they reported that this is in fact what has occurred- the recipient has experienced six months of successful interactions with staff and peers and is much more likely to be accepted for placement now. They also stated that the recipient is now among residents her own age and does not have the same type of programming that she found so unpleasant at the previous placement. Staff also stated that the guardian was very involved in the recipient's care and they met with the guardian throughout the discussion of the recipient's placement and the guardian consented to the plan that was agreed upon.

STATUTORY BASIS

The Nursing Home Care Act states that no resident shall be deprived of any rights, benefits or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States "solely on account of his status as a resident of a facility" (210 ILCS 45/2-101). Additionally, it states that every resident "shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record" (45/2-104 c).

The Nursing Home Care Act (210 ILCS 45/101 et seq.), states that a facility may involuntarily transfer or discharge a resident only for one or more of the following reasons:

1. for medical reasons;
2. for the resident's physical safety;
3. for the physical safety of the other residents, staff or visitors;
4. for late payment or nonpayment for the resident's stay (210 ILCS 45/3-401).

The Act states that when the transfer or discharge of a resident is mandated by the physical safety of the residents, staff or visitors of the facility, and is documented in the clinical record, the Department of Public Health shall be notified prior to any such involuntary discharge or transfer. The Department "shall immediately offer transfer, or discharge and relocation assistance to residents transferred or discharged" under this subparagraph (b), and the Department may place relocation teams as provided in Section 3-419 of this Act." (210 ILCS 45/3-402 b). The Act states that involuntary transfer or discharge of a resident from a facility must be preceded by a 21 day written notice except when an emergency transfer or discharge is ordered by the resident's physician or when the transfer or discharge is mandated for the physical safety of others (210 ILCS 45/3-402). The notice of involuntary discharge must include information regarding the right to request a hearing to appeal the discharge.

The Nursing Home Care Act outlines the requirements for care planning: Section 3-202.2a of the Act states, "A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable

level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (210 ILCS 45/2-104)"

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) mandates that any employee of a long term care facility that has reasonable cause to believe any resident with whom they have direct contact has been subjected to abuse or neglect "shall immediately report or cause a report to be made to the Illinois Department of Public Health", and anyone required under the Act to report abuse or neglect who fails to do so is guilty of a Class A misdemeanor (30/4). The Act states:

"All reports of suspected abuse or neglect …shall be made immediately by telephone to the Department's central register …or in person or by telephone through the nearest Department office. No long term care facility administrator, agent, or employee, or any other person shall screen reports or otherwise withhold any reports from the Department, and no long term care facility…shall establish any rules, criteria, standards or guidelines to the contrary.

….The report required by this Act shall include the name of the resident, the name and address of the nursing home at which the resident resides; the resident's age; the nature of the resident's condition including any evidence of previous injuries or disabilities, and any other information that the reporter believes might be helpful in establishing the cause of such abuse or neglect and the identity of the person believed to have caused such abuse or neglect."

The Mental Health and Developmental Disabilities Code outlines the process whereby a person 18 years of age or older who is subject to involuntary admission and in need of immediate hospitalization may be admitted to a mental health facility (405 ILCS 5/3-600 et seq.). This process requires a detailed statement of the reason for the assertion that the recipient is in need of involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion (3-601).

FACILITY POLICY

Alden does not have policy which specifically addresses involuntary hospitalization for psychiatric evaluation, however it does have policy and procedure addressing emergency transfers to hospitals. It states that the facility will make an emergency transfer when it is in the best interest of the resident and a physician's order is necessary for the transfer, along with documentation of the "events that lead up to the emergency transfer."

Alden also provided policy and procedure for the involuntary discharge of residents who are an endangerment to the physical safety of others. The notice of discharge is issued "as soon as practicable" to the resident and their family or representative. The notice must state the reason for the discharge, and provide contact information for the State Long Term Care Ombudsman and the Guardianship and Advocacy Commission. The physician must document in the clinical record the necessity of the discharge and issue an order for the transfer. The clinical record must show documentation that the discharge notice was issued to the resident and family member or

representative, and that orientation was provided to ensure the safe transfer or discharge of the resident. A hearing request form is attached to the discharge notice with an envelope addressed to the Illinois Department of Public Health (IDPH) regional office. The discharge is discussed with the family or representative and they are offered counseling services for before and after the transfer. This discussion and all the participants taking part in it are recorded in the clinical record.

The resident and their family or representative have the right to contest the discharge. In this case the IDPH will send notification of the hearing date, time and location within 10 days after receiving the hearing request to the facility and the resident. Policy allows for residents to be involved in planning the discharge and in choosing among alternative placements. Residents may stay in the facility up to the 34th day following the receipt of the involuntary discharge notice, or up to the 10th day following the receipt of the decision for discharge made by the IDPH, whichever is later.

CONCLUSION

The complaint alleges that the recipient was hospitalized repeatedly for psychiatric evaluation after an incident in which she was observed being slapped by another staff person. The QMRP summaries show that the recipient's behaviors had been increasingly aggressive from the period of three months before the slapping incident until the time the recipient was discharged from the facility. However, the recipient had only been hospitalized for a psychiatric evaluation one time in the 8 years before this incident. After the incident, the recipient was hospitalized 4 times in 3 months. These hospitalizations might have been justified, if the record supported them, however it does not. The record only contains one petition for involuntary hospitalization, and that is for the first hospitalization on 12/09/10. Staff reported that the facility was under close scrutiny for other unrelated incidents and felt compelled to respond immediately to aggressive events, however this is not the purpose of involuntary admission, which is meant to provide care for persons with mental illness who are subject to immediate hospitalization. Without the proper documentation and clinical support, the repeated hospitalizations appear under-supported and retaliatory. The HRA substantiates the complaint that the facility did not follow Code procedures when it began sending a recipient for psychiatric evaluations after a staff person reported to the police that she witnessed another person slap the recipient.

The record shows that the recipient was discharged to a skilled nursing facility, which, although not the first choice of the guardian, was clinically suitable for the recipient's needs, and agreed upon by the guardian. The HRA does not substantiate the complaint that the recipient was then discharged to a facility that was not qualified to treat her.

RECOMMENDATIONS

1. Train staff that for each involuntary hospitalization a petition is completed which offers a detailed statement of the reason for the assertion that the recipient is in need of involuntary admission, the signs and symptoms of mental illness, and a description of any acts, threats, or behaviors supporting the assertion.

SUGGESTIONS

1. The clinical record for this recipient does not reflect the recipient's treatment episode: There was no mention of the recipient's having been hit by a staff member and it was never addressed in her care plan, the interventions that staff reported were used to address the recipient's day program problems were not in the record, and the report of her aggressive incidents lacked any detail regarding what type of aggression was used, when, how and to whom. Facility representatives have assured the HRA that these deficiencies have been addressed since this incident and the HRA suggests that staff are trained in all aspects of care plan development and record keeping.

2. Include in the training on record keeping a reminder to make all clinical record entries legible.